AGING & INDEPENDENCE SERVICES
COUNTY OF SAN DIEGO • HEALTH AND HUMAN SERVICES AGENCY
LONG TERM CARE INTEGRATION PROJECT

NEWSLETTER

COORDINATING CARE ACROSS THE CONTINUUM

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Welcome

Our last newsletter featured two of our Community-based Care Transitions Program (CCTP) hospital partners' innovative solutions to improving health care delivery. Their work, along with our other two hospital partners, was recently recognized by the National Association of Counties (NACo) with an Achievement Award for the tremendous value the program is bringing to our county residents. This issue wraps up our feature of CCTP with a look at the remaining two of our hospital partners' innovative solutions that further demonstrate how the County of San Diego has contributed to improving healthcare outcomes while reducing healthcare costs.

Also featured in this issue is *The Alzheimer's Project*, another County program that received a 2015 NACo Achievement Award. As usual there are updates on the Coordinated Care Initiative (CCI) along with a couple Cal MediConnect success stories, as well as other information related to health care and long term services and supports.

THE ALZHEIMER'S PROJECT: A CALL TO ARMS

Did you know that there are approximately 60,000 San Diegans age 55 years and older living with Alzheimer's disease or other dementias (ADOD)? This figure is expected to grow to nearly 100,000 by 2030 representing a 30% increase in just eight years. While dementia is more prevalent among the older population, diagnosis of ADOD is occurring more frequently at an earlier age and once diagnosed an individual is facing a four to eight year life expectancy. As the nation's elderly population surges, Alzheimer's has become the sixth leading cause of death. Unfortunately, in San Diego County it has climbed to third exceeded only by cancer and heart disease.

As Alzheimer's disease reaches epidemic proportions San Diego County households and the region's healthcare system are feeling the strain. The vast majority of San Diego County's Alzheimer's patients (80%) are cared for at home by almost 137,000 family members. In 2012, caregivers provided an estimated 156 million hours of unpaid care, valued at nearly $2 billion. Alzheimer's caregivers provide 24-hour care and often neglect their own health at an estimated local cost of $75 million/year. It is forecasted that Alzheimer's disease will cost Californians approximately $16 billion this year in medical care and social supports. Nationally in 2010, Alzheimer's disease resulted in an estimated $109 billion in direct medical costs, surpassing heart disease ($102 billion) and cancer ($107 billion).

In May 2014, then Chairwoman Dianne Jacob and Supervisor Dave Roberts declared Alzheimer's disease as one of the region's leading public health priorities by launching "The Alzheimer's Project," an unprecedented initiative to develop a regional roadmap that comprehensively addresses this devastating disease. The Alzheimer's Project brought together the region's leading clinicians, researchers, caregivers, advocacy groups and leadership to develop recommendations to improve care and caregiver resources as well as to provide support for local efforts to find a cure. The project's recommendations encompass six major areas: Care, Clinical, Cure, Education/Awareness, Funding and Legislation. "The Alzheimer's Project: A CALL TO ARMS," report was presented to the County Board of Supervisors on December 2, 2014 and was unanimously adopted. The recommendations are meant to serve as a launching point for a multi-year effort to unite San Diego County for a cure and care.

CMS PROPOSES MAJOR UPDATE TO MEDICAID MANAGED CARE REGULATIONS

On May 26, 2015 the Centers for Medicare and Medicaid Services (CMS) proposed a rule to strengthen managed care for Medicaid and Children's Health Insurance Program (CHIP). It has been more than a decade since Medicaid and CHIP managed care regulations were last updated and the landscape of healthcare delivery has changed significantly during that time. The passing of the Affordable Care Act in 2010 has provided states the option to expand Medicaid eligibility to new populations, including seniors and persons with disabilities, and today approximately 58% of all Medicaid beneficiaries receive their benefits through capitated risk-based arrangements health plans. CMS's proposed rule offers a definition of LTSS and incorporates key principles from their May 2013 guidance on how to best implement managed long-term services and supports (MLTSS) programs. MLTSS is a vital component of California's Coordinated Care Initiative that is currently being implemented San Diego County and hence has significant impact on AIS and other CBOs contracting with our local Managed Care Organizations (MCOs). Organizations such as Justice In Aging, the National Association of Area Agencies on Aging (n4a), CalPACE and a whole host of others submitted comments on the proposed rule which were due at the end of July. CMS is currently reviewing all comments received and will incorporate them into the final rule which is expected to be released before the next Presidential election. You can read the rule here and review the comments here.

SAN DIEGO CARE TRANSITIONS PARTNERSHIP (SDCTP) INNOVATIONS

It's been two years since the Community-based Care Transitions Program (CCTP) was awarded to the San Diego Care Transitions Partnership (SDCTP). From this partnership, innovative solutions have emerged to improve health care delivery in San Diego County. In addition to the two that were described in the February newsletter, two more innovations are Crimson Real Time at Scripps Health and the UCSD/CSUSM Partnership at University California San Diego Health System. These innovations continue to show what can be accomplished in a community where there is collaboration and a shared vision.

Scripps Health

How do hospitals identify the right patients for the right intervention? Working with Crimson Real Time, Scripps has come up with a way to screen patients more efficiently and more effectively. An application for health care, Crimson Real Time (CRT) is a natural language processing model that is able to read text to identify patients at risk.

Here's a simplified description of how it works:

- Raw data is entered
- Hospital provided key words and terms are read
- Word patterns are analyzed to identify higher risk patients
- An algorithm is applied to extract complex concepts
- Rules (the reasoning) previously entered are applied
- Models that Scripps has built are applied to this information, e.g. noncompliance, readmission, etc.
- A more efficient list of patients to look at is produced

Scripps' inpatient and outpatient navigators utilize this list for case finding and triaging for services and the pharmacists can identify patients for enrollment into their system-wide Medication Therapy Management program. With the use of Crimson Real Time Scripps high need patients are differentiated from patients with high risk for readmission ensuring better care.

UCSD

"We need experts that understand what transitions of care is" – Eileen M. Hailey, MSN, RN, CNS, ACM.

CCTP highlighted the gaps in Transitions of Care knowledge, specifically the handoff between the hospital and upstream providers and the lack of patient centered planning and knowledge transfer for the UCSD Health System. Recognizing the need for training in transitions of care, UCSD partnered with California State University, San Marcos (CSUSM) and received a Health Resources and Services Administration (HRSA) Grant for Advanced Practice Nursing Students. This program is unique in that it will have an inter-professional collaboration approach that is currently used at UCSD free clinics and a curriculum in clinical and integrative medicine.

The program is set to roll out to undergraduate and graduate nurses in Winter 2016. It will focus on advanced practice nursing education for vulnerable populations with multiple chronic conditions. Nurses in this program will be taught to identify gaps in care , to anticipate the challenges, and to understand that you can't coach people in vulnerable populations when they have barriers. This population isn't listening when they don't have a home to go home to.

What's Happening

System of Transformation in California: Coordinating Care and Long-Term Services and Supports

The Patient Protection and Affordable Care Act (ACA) sought to change the care delivery and LTSS landscape

Signed into law in 2010, the ACA included provisions to transform the health care delivery and long-term services and supports systems for older adults. This brief summarizes California's implementation of key models from the ACA to improve care for older adults and people with disabilities, noting current accomplishments and recommendations for further system transformation.

Long -Term Care (LTC): Examining Attitudes Towards Person Centered Care

Most believe person-centered care policies will improve the quality of LTC

The extent of support for person-centered care policies differs among demographic groups. As government agencies and health care providers work to design and integrate person-centered care into long-term care planning, understanding older adults' attitudes toward different approaches is important for developing and communicating these concepts. This issue brief and data interactive highlight the differences.

Building the Business Case: Community Organizations Responding to the Changing Healthcare Environment for Aging Populations

Any healthcare organization (provider or payer) exploring partnership, specifically partnership with community providers, would benefit from engaging with the ideas and reflections in this paper.

New Federal Home and Community Based Services Rule

New federal Medicaid rules have set standards to ensure that Medicaid-funded home and community-based services are provided in settings that are not institutional in nature. States have until March of 2019 to ensure that all settings receiving Medicaid home and community- based funding come into compliance with the new rules. For more information please visit Justice In Aging

In Their Own Words

San Diego County Cal MediConnect
The Experience

Coordinating Care to Support Better Health, Safety, and Wellbeing

...a previously independent 73-year-old woman was passively enrolled into Cal MediConnect. Home supports and Care Plan Options ensured her safe discharge home alone from a skilled nursing facility after rehabilitation from lumbar surgery. In- Home Supportive Services and Community-Based Adult Services referrals were made and services are now in place. The member has remained safe and is able to be home, rather than institutionalized.

...a Case Manager arranged for an urgent appointment including transportation for a member with multiple admissions and ER visits to establish her newly assigned primary care physician. The member was able to renew prescriptions, obtain supplies, specialty referrals, and has not been readmitted.

Partner Spotlight

St. Paul's PACE

The Program of All-inclusive Care for the Elderly known as PACE is a program offered by St. Paul's Senior Homes & Services that is specifically designed to keep seniors in their home and out of nursing facilities. The PACE program is a shining example of person centered care whose keystone is care coordination. PACE provides transportation and coordinates all medical, social and home care services. PACE members are equipped with a comprehensive Interdisciplinary Care Team (ICT) that is composed of a primary care physician, center manager, registered nurse, physical, occupational and recreational therapists, social worker, dietitian, home care geriatric aide, PACE Center aides, and transportation representative. The ICT mobilizes other services including medical specialists, laboratory and other diagnostic tests, hospital and nursing home care as needed. For over 50 years St Paul's has been an innovator in the San Diego community with a reputation for providing exceptional care and their PACE program brings pride and dignity to many San Diego seniors!

St. Paul's PACE
Program of All-inclusive Care for the Elderly

CCI UPDATES

- **Cal MediConnect Health Risk Assessment (HRA) Data –** Cal MediConnect plans are required to conduct an HRA for each beneficiary within at least 90 days. DHCS has released an HRA dashboard summarizing the completion of HRAs by each Cal MediConnect plan. The HRA dashboard is available here.
- **Cal MediConnect Opt-Out data -** Breakdown by Language, Ethnicity, and Age can be found here.
- **DHCS Revised DUALS PLAN LETTER 15-005 on Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect.** This DPL supersedes DPL 13-002. Read the letter here.
- **DHCS Revised DUALS PLAN LETTER 15-001 on Interdisciplinary Care Team Requirements**. This DPL supersedes the previous DPL on the same topic and includes one significant change: the DPL states that the IHSS county social worker is a *required* member of the interdisciplinary care team. Read the letter here
- **DHCS DUALS PLAN LETTER 15-002 on Provider Preventable Conditions –** New DPL outlining the Cal MediConnect plans' reporting requirements with regard to provider preventable conditions. Read the letter here.
- **DHCS ALL PLAN LETTER 15-002 for MSSP Appeals & Grievances Under CCI –** Read the letter here.
- **DHCS Releases Revised Dual Plan Letter (DPL) on Continuity of Care -** The new DPL supersedes an earlier DPL on continuity of care released in September 2014 (DPL 14-004). Read the letter here.
- **San Diego County Tele Town Hall** - On February 10, 2015 the San Diego County CCI Advisory Committee hosted and collaboratively conducted an informative Tele Town Hall on Cal MediConnect for IHSS beneficiaries. The callers consisted of beneficiaries whose birthdays fell in February and March of this year. Greg Knoll, Executive Director of the Center for Health Education and Advocacy (CCHEA) and Chair of the CCI Advisory Committee moderated the call. Mr. Knoll was joined by subject matter experts Brenda Schmitthenner, Manager of the LCTIP, Jack Dailey, Senior Health Attorney at CCHEA, Michele Melden, Statewide Coordinator for the Cal MediConnect Ombudsman Program, and members of the UDW team. The group provided information about the CCI to participants on the call and answered their questions both on the air and following the call.

LONG TERM CARE INTEGRATION PROJECT

The next LTCIP meeting is on Friday, September 11, 2015 at the County Operations Center - AIS 5560 Overland Ave., 3rd Floor

Aging & Disability Resource Connection
ADRC of San Diego County
Linking you to home & community services

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY
Aging & Independence Services

LIVE WELL SAN DIEGO

CONTINUING EDUCATION

- **Dual Eligible Demonstrations: Justice in Aging's Toolkit on Design & Implementation**
- The SCAN Foundation's Linkage Lab Initiative prepares CBOs seeking to deliver care coordination services for effective partnership with health care entities through education and on-site technical assistance.
- The Disability Rights Education & Defense Fund announced three Promising Practices that Re-Envision the Independent Living Philosophy and Related Services as a Central Element of Both Care Coordination and Long-Term Services and Supports (LTSS). For more information click on the link.